

E-book

Transitioning to Value-Based Care in an Evolving Payment Landscape

Measure performance and increase efficiency up to 25%

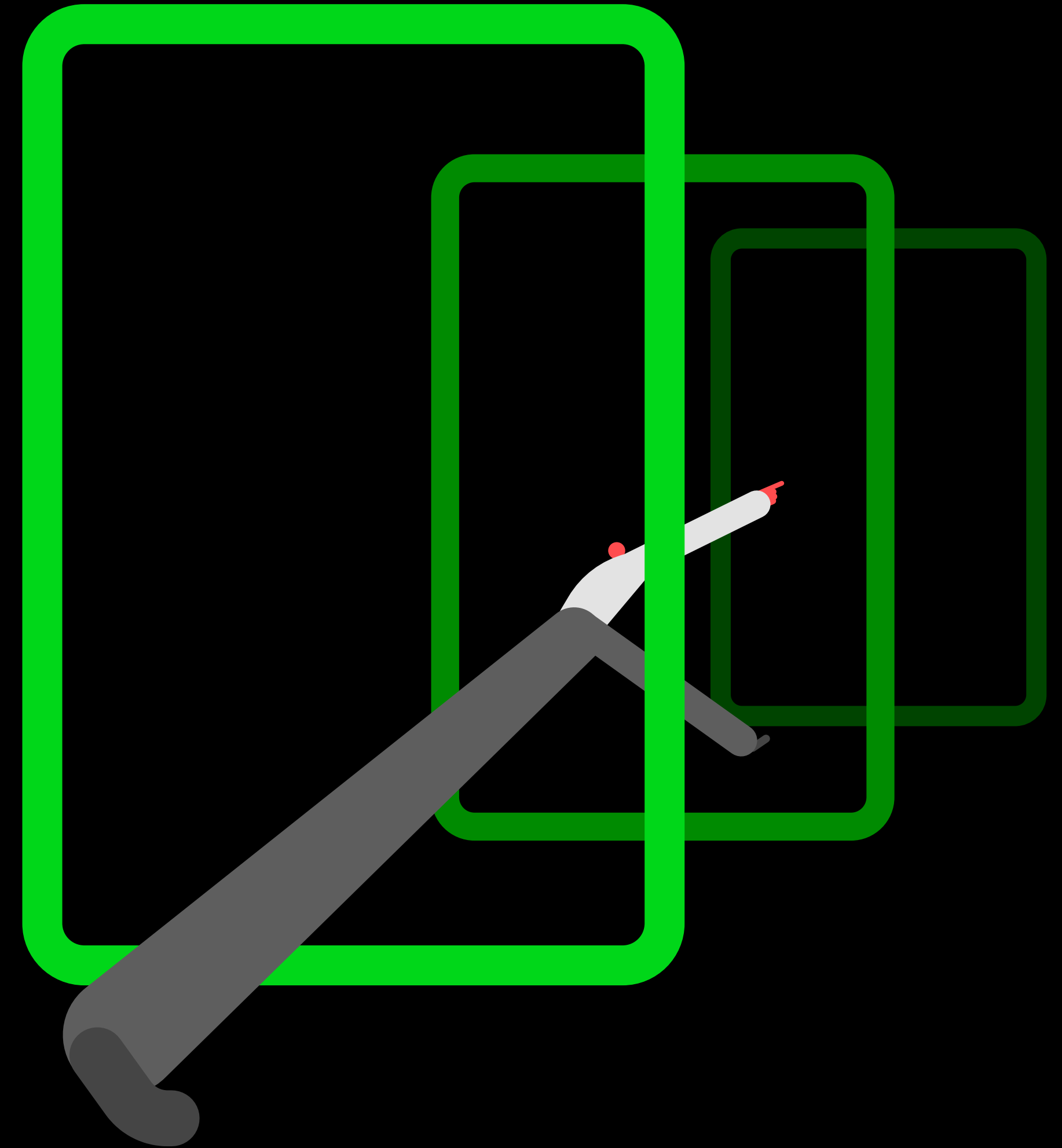
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Introduction

The financial landscape in healthcare is evolving, driven by ongoing changes in both public and private payment



These changes include increasingly thin operating margins, the shift toward consumer-driven healthcare, declining reimbursement rates, and changing reimbursement models. The fallout of this evolution has had a considerable impact on healthcare reimbursement.

Healthcare finance leaders must rethink revenue cycle management strategies as healthcare shifts away from fee-for-service reimbursement to value-based care payment models.

Value-based care

Moving toward value-based care

Drastic increases in healthcare costs have largely driven the United States to value-based programs.

The cost of healthcare is expected to reach a staggering \$6 trillion or about 20% of GDP by 2027.* Double-digit increases over the years, combined with an aging population, have led to the cost of healthcare quickly becoming unsustainable.

Value-based care, also known as pay-for-performance, provides incentives for achieving performance goals of efficiency and efficacy, while penalizing providers for poor patient outcomes, medical errors, and high costs. Value-based care began as an experiment, but its adoption has been rapid.

**CMS, "National Health Expenditure Data." December 2019.*

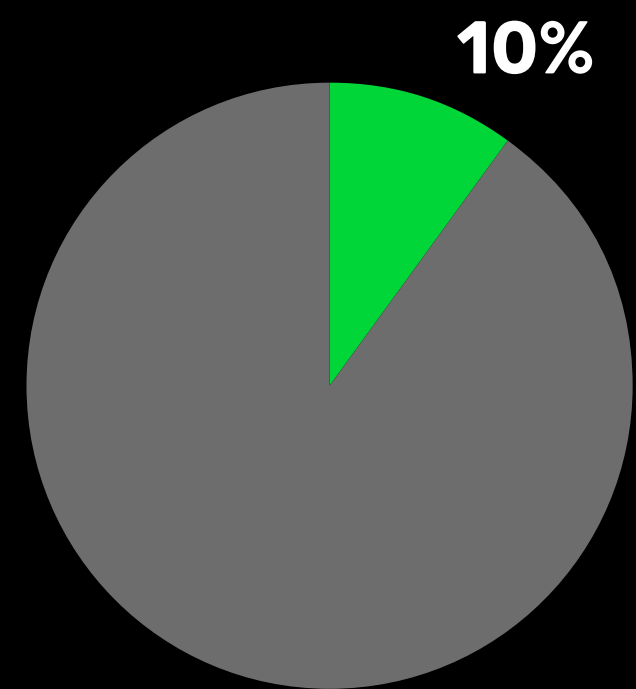


“Our value-based programs are important because they’re helping us move toward paying providers based on quality, rather than the quantity of care they give patients.”

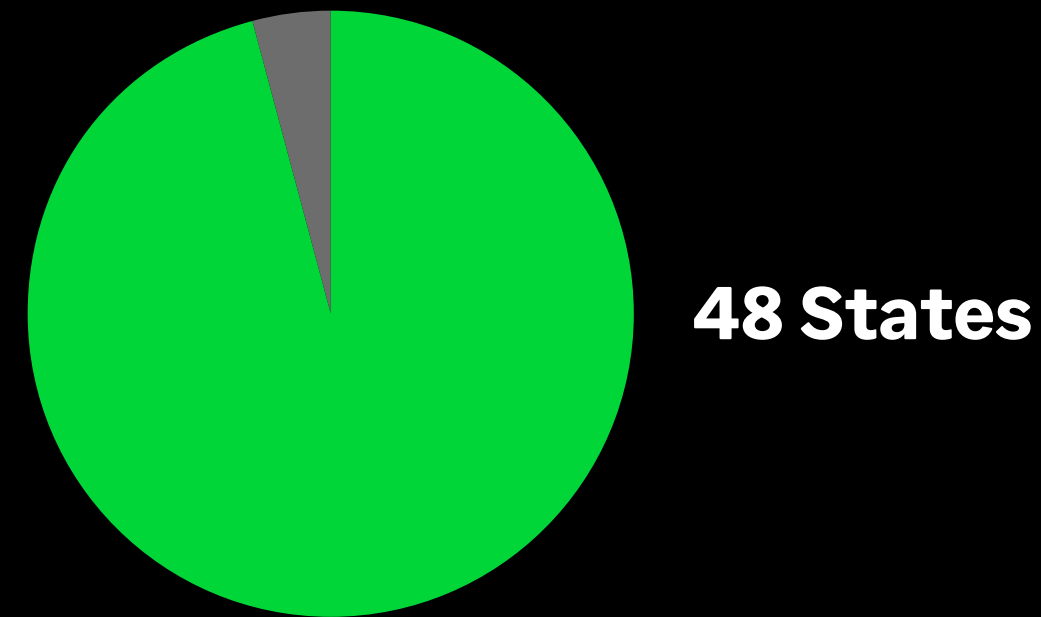
~ Centers for Medicare and Medicaid Services (CMS)

Value-based care by the numbers

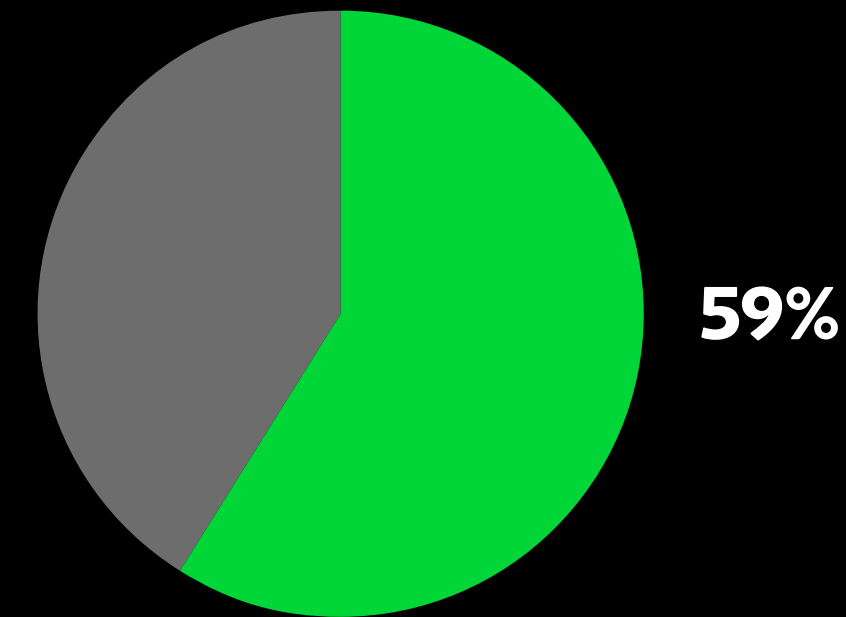
The percentage of population covered by Accountable Care Organizations—nearly 33 million Americans¹



The number of states that have implemented value-based payment programs²



The percentage of U.S. healthcare reimbursements tied to value-based care³



Further proof of the accelerating transformation can be found in the CMS plan to launch new direct-contracting global fee models in 2020. That program alone is expected to shift a quarter of the Medicare population away from fee-for-service.

1: Health Affairs. "Recent Progress In The Value Journey". 2018.
2: Primary Care Collaborative, Value-Based Care in America. 2019.
3: APM Measurement, Health Care Payment Learning & Action Network. 2019.

New delivery models

With new payment models comes new delivery models

The patient-centered medical home is a care delivery model in which patient treatment is coordinated through the primary care physician to ensure patients receive the necessary care when and where they need it, in a manner they can understand. Care is facilitated by registries, information technology, health information exchange, and other means.

An accountable care organization (ACO) is a formally organized entity, consisting of physicians, hospitals, and other relevant health service professionals that elect to join together and are responsible through contracts with payers for providing a broad set of healthcare services to their Medicare patients.



Direct patient or employer contracting is one in which a patient contracts directly with a physician, clinician, or practice to pay directly out-of-pocket for some or all medical services provided. Direct patient contracting models include several different arrangements, including direct primary care and concierge care.

American College of Physicians. "Delivery and Payment Models." 2019.

Making the shift

Adapting to value-based care payment models

When negotiating a value-based contract, data is key.

When evaluating value-based contracts, healthcare providers need to address how patients will be assigned and attributed to those providing healthcare. Physicians will be compensated or penalized based on the care outcome and cost of that specific patient population. Specifically, in a pay-for-performance model, the agreement should outline how patients will be assigned for purposes of incentive payments. Specific clinical criteria for patient assignment should be spelled out in the agreement. Understanding the current costs of that population in your practice is essential to negotiating that agreement.



The payer and the physician must engage regularly to ensure that the pay-for-performance agreement is working for both parties. In order to do this successfully, healthcare organizations need timely access to accurate clinical and financial data.

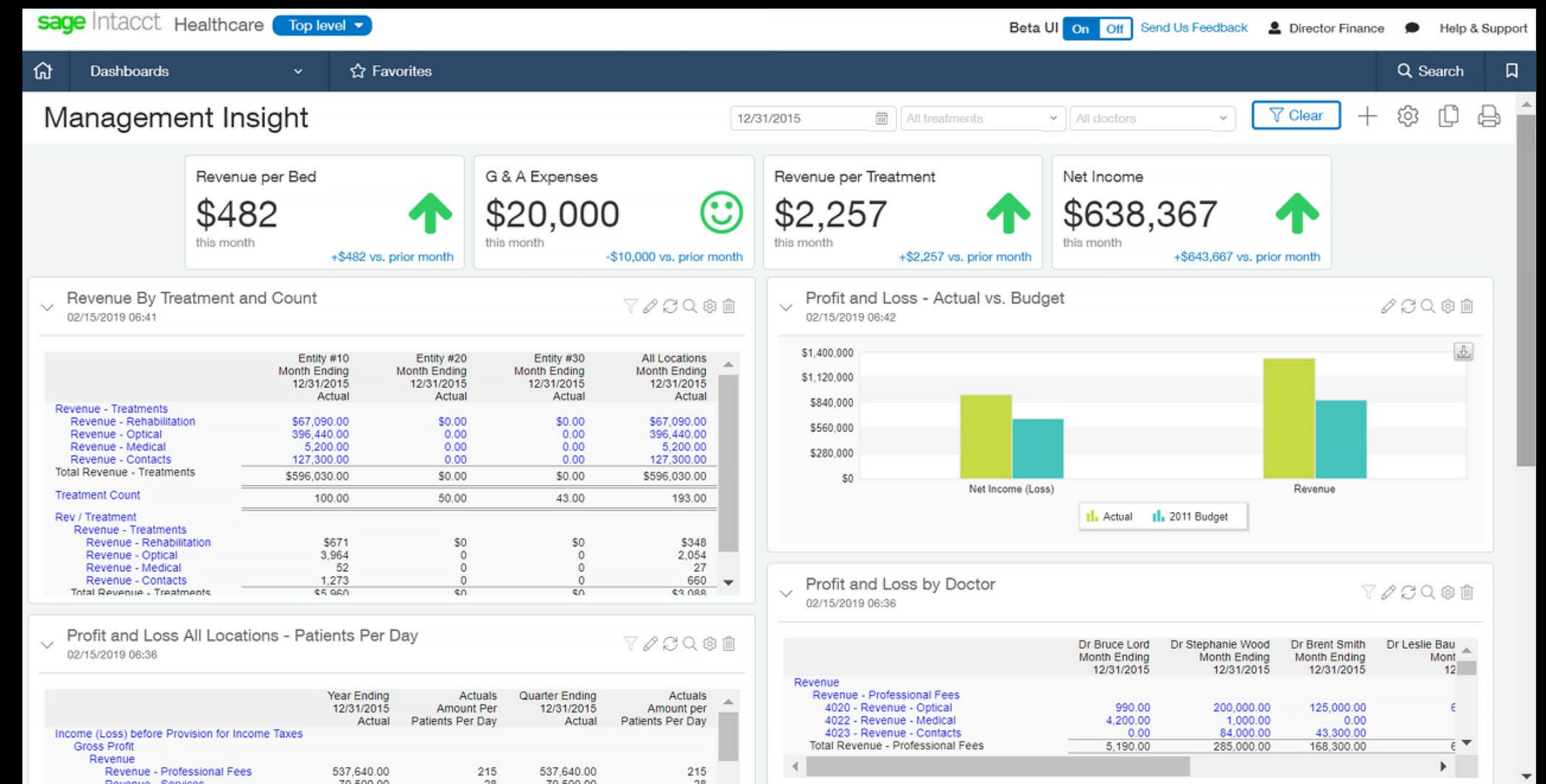
Key performance indicators

Key measurements for success

In order to measure the performance of contracts and make strategic decisions about the direction of your practice, you need access to financial key performance indicators (KPIs).

These are some of the KPIs important to track in order to understand the true performance of a value-based contract:

- Cost/revenue per treatment
- Cost/revenue per patient
- Revenue/expense per location
- Revenue/expense per referral
- P&L by contract
- P&L by budget
- P&L by location



When you're able to track important trends like revenue per bed and per treatment and can drill down to see exactly where those numbers are coming from, you gain a better understanding of which areas of your practice are outperforming others. This information can empower you to make strategic decisions about the future of your contracts or practice.

Real world example

How clinic performance visibility helps maintain precise gross margin targets

Vera Whole Health, an advanced primary care provider, is embracing the shift to value-based care by focusing on whole patient health.

- Vera is rapidly growing and opening new locations, using Sage Intacct to track expenses and project future costs. These are the KPIs they track using Sage Intacct:
 - Clinic margins
 - Support overhead
 - Staffing projections
 - Cash flow forecasts to monthly enrollees, patient visits
 - Actual expenses per member, per month at the department, entity or entire organization level
- These KPIs inform strategic discussions with clients and helps Vera demonstrate its value as a business partner.
- Overall, Vera has increased their finance team efficiency by 25% and cut their reporting from 10 days to 10 minutes using Sage Intacct.





Customer video

Hear how Vera Whole Health increased finance team efficiency by 25%



Case study

Read how Vera Whole Health accelerated time-to-insight by 10x

“Our pricing is based on achieving a target margin, so when we open new locations, our leadership team and board track performance. That wasn’t something we were able to easily provide before, but with Sage Intacct, we can see right away whether new locations are sustaining their margins. This helps us decide when we need to reassess our strategy and make a successful case when we need to adjust pricing.”

~Brian Goldrick, Director of Accounting, Vera Whole Health



Key takeaways

Shifting business-as-usual to embrace value-based care

The healthcare industry continues to shift toward value-based care and away from fee-for-service.

As a result, healthcare practices must juggle the dichotomy of improving care, while reducing costs. In order to do this, organizations must shift the way they operate today in order to be successful in a value-based care environment. The ability to measure and track key performance indicators in real-time is essential to both the negotiation and success or failure analysis of a value-based contract.



Sage Intacct is the #1 cloud financial management system for data-driven, growing healthcare organizations

**Our security safeguards have been certified
as HIPAA- and HITECH-compliant by Avertium
(formerly Sword & Shield), and Sage Intacct is the
only accounting software endorsed by the AICPA.**





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